

**FINAL MINUTES**

**MEETING OF:**

**PATIENT SAFETY AUTHORITY**

WYNDHAM HOTEL  
95 PRESIDENTIAL AVENUE  
GETTYSBURG, PENNSYLVANIA

TIME: 3:45 P.M.

DATE: March 5, 2007

**AGENDA**

- I. Call to Order
- II. Approval of January 9, 2007 Meeting Minutes
- III. Report of the Board Chair
- IV. Report of the Board Administrator
- V. Committee Reports
  - Strategic Planning Committee, Dr. Stanton Smullens
  - Others, if necessary
- VII. PA-PSRS Update
  - Presentation - PA-PSRS Discussion Groups, William M. Marella MBA, PA-PSRS Project Manager at ECRI
  - Presentation - PA-PSRS Workgroup on Pharmacy System Safety, Michael J. Gaunt PharmD, PA-PSRS Clinical Analyst at ISMP
- VIII. Old Business
- IX. New Business
- X. Public Comments
- XI. Adjournment

**PATIENT SAFETY AUTHORITY**

**March 5, 2007**

**Board Members:**

Anita Fuhrman, R.N., B.S.  
Joan M. Garzarelli, R.N., MSN [by telephone]  
Roosevelt Hairston, Esquire  
Ana Pujols-McKee, Chairperson  
Gary A. Merica, R.Ph. [by telephone]  
Stanton Smullens, M.D. [by telephone]  
Marshall Webster, M.D.

**PSA Personnel:**

Mike Doering, Acting Patient Safety Authority Administrator  
Laurene M. Baker, Communications Director  
Sharon Hutton, Administrative Assistant  
Barbara Holland, Esquire, Board Counsel [by telephone]

**ALSO PRESENT:**

William Marella, ECRI, PA-PSRS Project Manager  
John Clarke, M.D., ECRI, PA-PSRS Clinical Manager  
Michael J. Gaunt, ISMP, PA-PSRS Analyst

## PATIENT SAFETY AUTHORITY

MARCH 5, 2007

\*\*\*

The regularly scheduled meeting of the Patient Safety Authority was held on Monday, March 5, 2007 at the Wyndham Hotel in Gettysburg in conjunction with HAP's Patient Safety Symposium. Ana Pujols-McKee, Chairperson, called the meeting to order at 3:45 p.m.

\*\*\*

Ms. Pujols-McKee gave a brief opening welcoming everyone to the meeting. Then there was a brief period of introduction of all the members that were present and also ones that were present by telephone.

\*\*\*

## Approval of Minutes

The first item was the approval of the January 9, 2007 meeting minutes. This was moved and seconded. The minutes were approved as they stood.

\*\*\*

## Report of Board Administrator

The first thing noted was that there were certain abortion facilities that must report through PSRS now and that many of them have turned in their patient safety plans. There are also some training programs coming up. The first one

is Failure Mode and Effects Analysis. That is being given in three locations; Pittsburgh May 22 and 23, Gettysburg June 6 and 7, and Bethlehem June 13 and 14. Notices will be going out on these. Twelve continuing education credits will be provided for nurses and physicians. New user training is also being held on the same dates to minimize expenses and time. Focus group sessions have been completed. There was some good information and outcomes from this. The information has been helpful in helping the Board develop a strategic plan. Last month, the board met with Dr. Jim Bagian from the Veterans Administration and National Patient Safety Center to discuss the plan and ensure the objectives of the plan were on target with improving patient safety in the Commonwealth. A draft of the strategic plan has been completed which includes, among other inputs, the information obtained from the strategic planning session and the focus group information. The board will discuss the plan outside of a public meeting and vote to ratify at the next meeting. A briefing on the interface project was also given with approximately 33 percent of all Incidents expected to be coming through the Interface soon. In other business, there is need to set a committee up for the annual report coming due.

\*\*\*

## Report on Strategic Planning

It was noted that the Patient Safety Authority was honored by receiving the Eisenberg Award. The John Eisenberg Award is the highest quality and safety award that's given in this country. There are areas of focus for this group, one is collaboration with the PSA officers and different organizations in the health care community. Also there is work to be done between state sponsored agencies and the PSA to communicate more and work towards common objectives. For example, a statewide focus on the reduction of infections would mean working with PHC4 to improve infection information and education. The second element of the strategic plan is that of education. Some areas of focus in education would begin with educating facility boards about patient safety and working with frontline caregivers. And the third element of the strategic plan is looking at our taxonomy. There are many areas of inconsistency in reporting which need to be addressed. These are the three primary elements that will receive the Authority's focus.

\*\*\*

Presentation by Mr. Marella

The PSO focus group project began a couple of months ago to help determine how the Authority should invest its

resources to better serve the patient safety community. The objective was to gain insight on what PA-PSRS should be doing to help improve patient safety. The discussions in these meetings turned out to be very valuable and productive. There were a total of three meetings held across the state with diversity in facility-type representation and frequency of the use. Through the focus groups the Authority learned the patient safety officer often holds many roles and titles within the facility. Most say they have adequate access to senior management, but not necessarily their board. Most PSOs agree that educating boards of trustees on patient safety is a crucial element to improving patient safety. Most PSOs also agreed that getting senior management or physicians to focus on a certain patient safety issue was fairly easy to do, the challenge is getting everyone to sustain patient safety momentum on a continual basis. Patient Safety Officers also want more people on the frontlines educated about patient safety. They asked the Authority to help them build a curriculum that would allow them do that. PSOs also would like reporting requirements to be more standardized. The obtuse nature of the law has caused issues. For example, some PSOs get caught in the middle when they have physicians that work in multiple facilities. The same event

is being reported differently depending on the facility where the event happened. Also regarding physicians PSOs would like to educate them more about disclosure of Serious Events. PSOs added that a venue where they can get together and discuss issues, like the focus group venue, is very helpful and they would like more opportunities to do that. While benchmarking is not a priority of the PSOs since all information is reported differently making it difficult to do, PSOs have said they've made hundreds of changes as a result of guidance given in Patient Safety Advisories. However, benchmarking alternatives that help facilities improve patient safety are being considered.

\*\*\*

Report from Michael Gaunt on Electronic Pharmacy System survey.

The study involved 30 volunteer PA-PSRS facilities. Survey questions focused on their electronic pharmacy systems and their accuracy and efficiency in catching errors of duplicate orders, conflicting medications prescribed and distribution orders. The results of the survey showed that out of 17 potential errors, only two facilities caught all 17 errors. One participating facility's computer system caught only one of the 17 errors. A similar electronic pharmacy system survey was done by the Institute for Safe

Medication Practices eight years ago, yielding similar results. Many of the systems allow users to override serious warnings. This is another cause for concern with the often outdated systems. Results of the entire study will be published in a Supplementary Patient Safety Advisory. One of the guidelines suggested in the Advisory will be that facilities continually upgrade their systems to ensure errors are being caught. Other useful guidelines include working with vendors to ensure the latest information is reaching the facility but keeping those "alerts" to a minimum by not sending "nuisance" alerts. The Authority is hopeful that the Advisory will give other non-participating facilities the same opportunity to follow the guidelines suggested and improve the safety their electronic pharmacy systems. The Authority is considering a follow-up study in two years to see if improvements are being made.

\*\*\*

The floor was then opened to a question and answer period. Questions from the PSOs in the audience were varied. They included questions and comments regarding the inconsistency of reporting and the problem with the harm score accurately conveying the harm of the event being reported. Dr. John Clarke gave a detailed answer and asked the PSO to fill out

a form given to audience in regard to the issue for more feedback. Another question concerned the PSOs problems with the disclosure letter after a Serious Event has occurred. The Authority legal counsel, Barbara Holland, answered the question after clarification was made as to the genesis of the disclosure letter [Act 13].

\*\*\*

After more comment, the meeting was adjourned.

\*\*\*

R.O'B/S